TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sentrix Pharmacy and Discount, L.L.C.

Respondent Name
Amarillo ISD

MFDR Tracking Number
M4-18-0755-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
November 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier, Old Glory Insurance Company, failed to take final action on the claim within the 45-day period set forth in TAC §133.240."

Amount in Dispute: $2,078.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This complaint indicates we failed to respond to two billings filed to us for DOS 9/5/17. Our records indicate both billings were received and both were responded to. I have attached copies of both EOB's issued to Sentrix RX."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2017	Pharmacy Service – Compound	$2,078.06	$1,718.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 219 – Based on extent of injury.
   - 722 – The extent of injury has been disputed. This treatment is unrelated to the compensable workers' compensation injury.

- 18 – Exact duplicate claim/service.
- 216 – Based on the findings of a review organization.
- 224 – Duplicate charge.
- 727 – Based on the findings of a peer review, treatment exceeds ODG and would require preauthorization.

Issues

1. Did the insurance carrier support the issue of extent of injury in accordance with 28 Texas Administrative Code §133.307?
2. Did the insurance carrier support the issue of medical necessity in accordance with 28 Texas Administrative Code §133.307?
3. Did the insurance carrier support the issue of preauthorization in accordance with 28 Texas Administrative Code §134.530?
4. Is Sentrix Pharmacy and Discount (Sentrix) entitled to reimbursement for the disputed compound?

Findings

1. Sentrix is seeking reimbursement of $2,078.06 for a compound dispensed on September 5, 2017. Amarillo ISD denied disputed compound, in part, with claim adjustment reason codes 219 – "BASED ON EXTENT OF INJURY," and 722 – "THE EXTENT OF INJURY HAS BEEN DISPUTED. THIS TREATMENT IS UNRELATED TO THE COMPENSABLE WORKERS' COMPENSATION INJURY."

   28 Texas Administrative Code §133.307(d)(2)(H) requires that "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title…"

   Submitted documentation does not include a Plain Language Notice regarding a dispute of extent of injury. Therefore, the division finds that the denial for extent of injury is not supported.

2. Amarillo ISD also denied the disputed compound with claim adjustment reason codes 216 – "BASED ON THE FINDINGS OF A REVIEW ORGANIZATION."

   28 Texas Administrative Code §133.307(d)(2)(I) requires that "If the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title…"

   Submitted documentation does not include a copy of documentation that supports an adverse determination in accordance with §19.2005. Therefore, the division finds that the denial for medical necessity is not supported.

3. Amarillo ISD also denied the disputed compound with claim adjustment reason code 727 – "BASED ON THE FINDINGS OF A PEER REVIEW. TREATMENT EXCEEDS ODG AND WOULD REQUIRE PREAUTHORIZATION."

   28 Texas Administrative Code §134.530(b)(2) states that preauthorization is **only** required for:

   - drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;
   - any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and
   - any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   The division finds that the compound in question does not include a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. Amarillo ISD failed to articulate any arguments to support its denial for preauthorization. Therefore, the division concludes that the compound in question did not require

preauthorization. For this reason, the denial of payment for this reason is not supported. Therefore, the disputed compound will be reviewed for reimbursement.

4. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider; or
   (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Salt Stable LS Base	00395602157 Brand Name	$3.36	170.4 gm	$624.07	$572.54	$572.54
Baclofen 4%	00395803243 Generic	$35.63	9.6 gm	$427.56	$342.05	$342.05
Amitriptyline 2%	00395804843 Generic	$18.24	4.8 gm	$109.44	$87.55	$87.55
Ketoprofen 10%	00395805643 Generic	$10.45	24.0 gm	$313.50	$250.80	$250.80
Amantadine 8%	00395805843 Generic	$24.225	19.2 gm	$581.40	$465.12	$465.12
Gabapentin 5%	10695003507 NDC not valid	NA	12.0 gm	$0.00	$360.00	$0.00
Compound Fee	NA	NA	NA	$15.00	$0.00	$0.00
					Total	$1,718.06

The total reimbursement is therefore $1,718.06. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,718.06.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,718.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 1, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.